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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Cabret</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Cabret</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Frederick</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabret County Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X St. Leonard</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE M. BARNES</u>		4. DATE OF DEATH Month Day Year <u>July 26, 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1883</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Monnett</u>		14. MOTHER'S MAIDEN NAME <u>Oletha Stinnett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>James Barnes - Broome Island, Ind</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>420.1</u> DUE TO <u>Coronary Thrombosis & myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Chronic renal disease</u> (b) <u>Chronic renal disease</u> (c) <u>Chronic renal disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 20</u> 19 <u>61</u> , to <u>July 26</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>July 20</u> 19 <u>61</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R. E. Villars</u>		22b. DATE SIGNED <u>7/28/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. E. Villars</u>		22d. ADDRESS <u>She on road</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 29, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Watkins Memorial Cem</u>		23d. LOCATION (City, town, or county) (State) <u>St. Creek, Cabret Co., Ind</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Harkness & Son - Mutual, Ind.</u>		25. REC'D BY REGISTRAR <u>Aug 1 '61</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7747

CERTIFICATE OF DEATH

07738

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Barstow</u> c. LENGTH OF STAY IN lb <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>—</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Barstow (Rural)</u> d. STREET ADDRESS <u>—</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>W.</u> Last <u>Bowen</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 19, 1879</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. BIRTHPLACE (County & State, or foreign country) <u>Calvert Co. Md</u>		11b. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Bowen</u>	
14. MOTHER'S MAIDEN NAME <u>Agnes Virginia Puckler</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-366594</u>		17. INFORMANT <u>Kenneth D. Bowen, Prince Frederick Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>610X</u> DUE TO <u>Fractulation (Uremia)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>—</u> (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 2, 1959</u> to <u>7/15, 1961</u> , that (I) (we) last saw the deceased alive on <u>7/15, 1961</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Pepe J. St</u>				22b. DATE SIGNED <u>—</u>		22c. PHYSICIAN'S NAME (Type) <u>—</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b. DATE THEREOF <u>July 17, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.A. Harkness Son, Mutual Md.</u>				25a. REC'D BY REGISTRAR <u>—</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
7748		Item 1, File # - 306 2/5/62 cc Reg. Dist. No. 07739					
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL or nearest town) N Beach		c. LENGTH OF STAY IN IB 12 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) N Beach			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1st + Erie		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Benjamin Hoover				4. DATE OF DEATH July 24 1961			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH 11 Jan 1910 51 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction Work		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? no		16. SOCIAL SECURITY NO. 225-16-0835		17. INFORMANT Herbert Hoover N Beach MD Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE J. Weems				DATE SIGNED 24 July 61			
EXAMINER'S NAME (Type) J. Q. Weems				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1961		22c. NAME OF CEMETERY OR CREMATORY Prolick Cemetery		22d. LOCATION (City, town, or county) (State) Lorton Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hutchins Funeral Home Clwings md.				24a. REC'D BY REGISTRAR DATE JUL 27 61		24b. REGISTRAR'S SIGNATURE	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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[Faint, mostly illegible handwritten text follows, likely containing patient information, cause of death, and examiner details.]

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7749

07740

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randall Cliffs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mildred</u> First <u>Irene</u> Middle <u>Johns</u> Last <u>Wilcox</u>				4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/13/1901</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Noah Wilson Welch</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Mae McCourte Wilcox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-07-8107</u>		17. INFORMANT James Johns <u>Randall Cliffs, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident (stroke)</u> 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/10/1959</u> to <u>7/22/1961</u> that (I) (we) lost saw the deceased alive on <u>7/22/1961</u> and that death occurred at <u>3:45a.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE <u>7/23/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Weems, M.D.</u>	
22d. ADDRESS <u>c/o Calvert County Hospital</u> <u>Prince Frederick, Md.</u>				22e. REC'D BY REGISTRAR <u>BABUL 27 '61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/26/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Ft. Myer Va.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home-Upper Marlboro, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

[Faint, mostly illegible text covering the majority of the page, possibly a memorandum or report. Some fragments are visible, such as "The following information was obtained from..." and "On..."]

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7750

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07741

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Plant Creek</u> c. LENGTH OF STAY IN b. <u>7</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EDWARD C. LICHTENBERGER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cabot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Plant Creek</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward C.</u> Middle <u>Lichtenberger</u> Last <u>Lichtenberger</u>		4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>111</u>	6. COLOR OR RACE <u>10</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/29/95</u>
9. AGE (In years, months, and days) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Madam</u>	11. BIRTHPLACE (State or foreign country) <u>Unknown</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George M. Lichtenberger</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Klinebinst</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mary Sucreth - 1112 N. Sec. St. York, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>782.4</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in home where he lived alone</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>3</u> <u>7</u> <u>14</u> <u>1961</u> Hour <u>p. m.</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. City or town <u>Plant Creek</u> (County) <u>Cabot</u> (State) <u>Md</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/14/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Burial</u>		22b. DATE THEREOF <u>7/18/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>		22d. LOCATION (City, town, or county) <u>York, Pa</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Mutual, Ind.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 18 '61</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>William S. Riana</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07742

7751

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabaret Beach c. LENGTH OF STAY IN TB 4 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Ind b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabaret Beach d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jean Last Macdonald Middle McDonald		4. DATE OF DEATH Month July Day 10 Year 1961	
5. SEX F	6. COLOR OF RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1896 9. AGE (In years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Elger		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. No	
17. INFORMANT Louis D. Macdonald - Cabaret Beach, Ind.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from January, 1961 to July, 1961 that (I) (we) last saw the deceased alive on July 7, 1961 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Page C. Jett		22b. DATE SIGNED 7-10-61	
22c. PHYSICIAN'S NAME (Type) Page C. Jett		22d. ADDRESS Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF July 11, 1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town or county) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE A. A. Hackman & Son - Mutual, Ind.		25a. SEC'D BY REGISTRAR DATE JUL 12 '61	
ADDRESS _____		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7752

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07743

1. PLACE OF DEATH a. COUNTY CALVERT		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach		c. LENGTH OF STAY IN lb MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D. C. b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1439 Euclid St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FORREST		First FORREST		Middle ROBERT		Last MULNIX		4. DATE OF DEATH July 12 1961		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X		8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months 38 Days		11. IF UNDER 24 HRS. Hours 38 Min.		12. BIRTHPLACE (State or foreign country) POLO IL		13. CITIZEN OF WHAT COUNTRY? USA.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY SALESMAN		11. BIRTHPLACE (State or foreign country) POLO IL		12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME FORREST ROBERT MULNIX		14. MOTHER'S MAIDEN NAME LAURETTE MULNIX		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES	
16. SOCIAL SECURITY NO. 308-16-1800		17. INFORMANT W. CHAMBERS, JR.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty infiltration of liver DUE TO (b) Acute alcoholism DUE TO (c) Acute alcoholism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute alcoholism		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour 19 a.m. p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Washington		(County) D. C.		(State) D. C.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
21. ACTUAL SIGNATURE Russell S. Fisher, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-12-61		22c. NAME OF CEMETERY OR CREMATORY Acacia Park		22d. LOCATION (City, town, or country) Washington, D.C.		22e. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE JUL 18 '61	
23. FUNERAL DIRECTOR 44 Cook Inc		ADDRESS 1207 15th Ave SE		24. REC'D BY REGISTRAR JUL 18 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. DATE JUL 18 '61		24d. REGISTRAR'S SIGNATURE Arthur S. Kraus		24e. DATE JUL 18 '61	

7753 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

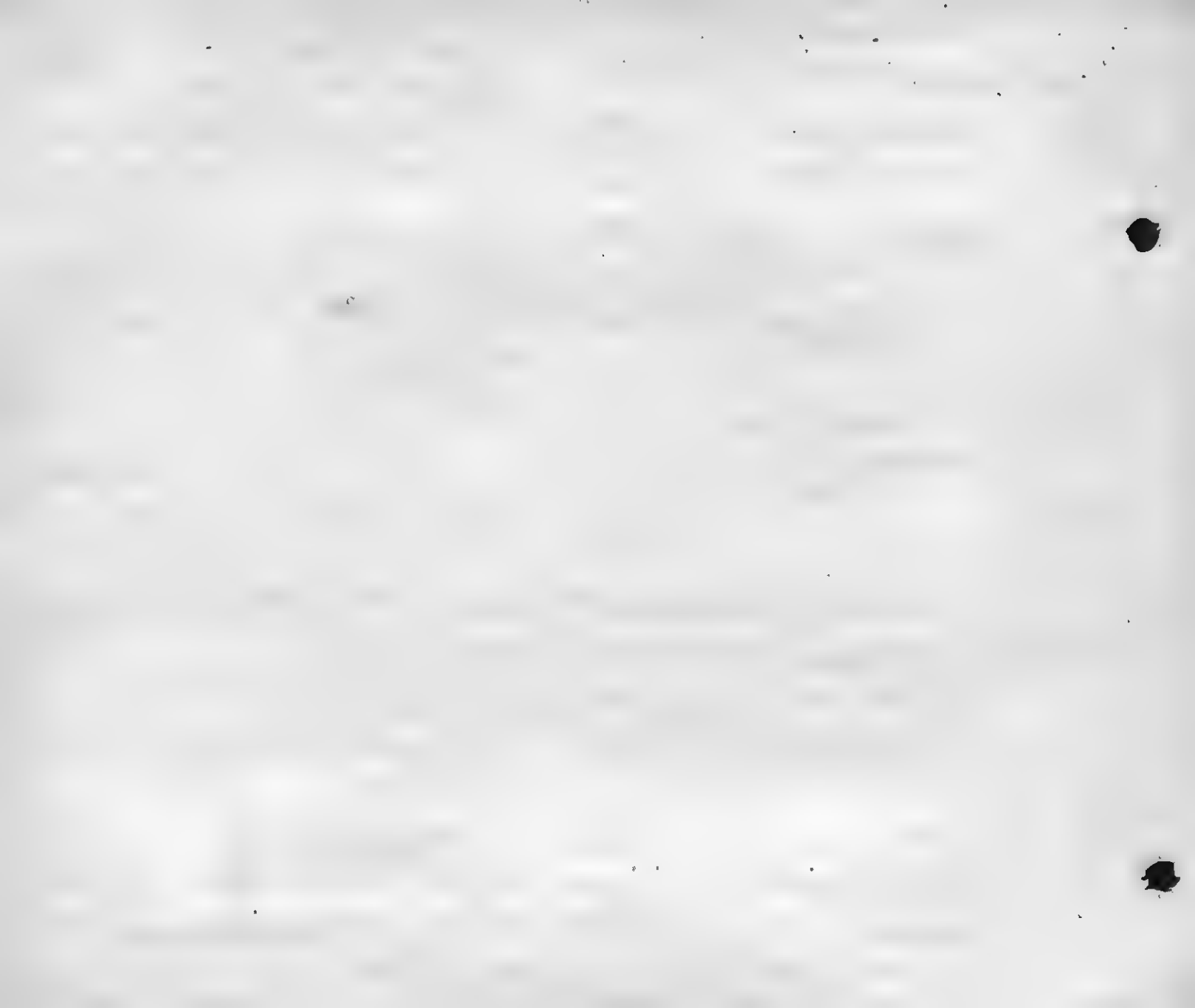
Reg. Dist. No. 07744

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN <u>W. Beach</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN <u>W. Beach</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Clifford</u> Last <u>Wendell</u> DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1961</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 7 1918</u> 9. AGE (In years, <u>43</u> yrs.) IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Primarily</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Beach Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry Hester Wendell</u>		14. MOTHER'S MAIDEN NAME <u>Wendell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>1943-1946 577-01-3796</u>	
17. INFORMANT <u>H. J. Wendell, W. Beach Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>322.2</u> DUE TO <u>Secularic poison</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>322.2</u> DUE TO <u>Secularic poison</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>found dead in bed</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>530</u> p. m. Month, Day, Year <u>7 16 1961</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>W. Beach</u> (County) <u>Calvert</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>7-19-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Urbington National</u>		22d. LOCATION (City, town, or county) (State) <u>Urbington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home Owings Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 19 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. Thur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A75ME
5M 9/60



7755 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07746

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b 3 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle E. Last Stafford				4. DATE OF DEATH Month July Day 29 Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/73		9. AGE (In years last birthday) 87 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Benjamin Stafford				14. MOTHER'S MAIDEN NAME ? Bowen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Frank Stafford-Barstow, Ind.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO mesenteric thrombosis - toxemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterial sclerosis - toxemia (c) arterial sclerosis - toxemia							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 27, 1961 to July 29, 1961 that (I) (we) last saw the deceased alive on July 29, 1961 , and that death occurred at 8:55 M, from the causes and on the date stated above.							
22a. SIGNATURE R de Villarreaga				22b. DATE SIGNED 7/29/61		22c. PHYSICIAN'S NAME (Type) R de Villarreaga	
22d. ADDRESS St Leonard, Md		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22g. DATE SIGNED 7/29/61	
23a. BLR A., CREMATION, REMOVAL (Specify)		23b. DATE THEREOF July 31, 1961		23c. NAME OF CEMETERY OR CREMATORY Barstow Cemetery		23d. LOCATION (City, town, or county) (State) Barstow - Calvert Co., Ind	
24. FUNERAL DIRECTOR'S SIGNATURE G. D. Harkness & Son - Mutual, Ind.				25a. REG'D BY REGISTRAR Aug 1 61		25b. REGISTRAR'S SIGNATURE William S. Hanks	

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 037747

7755

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>N. Beach</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>N. Beach</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>510 - 4th Street</i>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Sarah Elizabeth Sullivan</i>		4. DATE OF DEATH Month <i>7</i> Day <i>6</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <i>12</i> Year <i>1879</i>
9. AGE (In years and birthday) yrs. <i>81</i>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FW</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>in our home</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edmund Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Julia Richell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>Ms M. E Davis N. Beach Md</i>	
17. INFORMANT <i>Ms M. E Davis N. Beach Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> DUE TO <i>Age</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Age</i> DUE TO (c) <i>Age</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had heart attack 12 hrs</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>7/6/61</i> Hour <i>8</i> a.m. <i>19</i> p.m.		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7/6</i> to <i>7/6</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>7/6</i> , 19 <i>61</i> , and that death occurred at <i>3 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. W. Ward</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>7/6/61</i>	
PHYSICIAN'S NAME (Type) <i>H. W. WARD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>7/8/61</i>	<i>Mt. Olivet</i>	<i>Washington, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home, Inc.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 10 '61</i>	
ADDRESS <i>Mt. Rainier, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

Reg. Dist. No. 07748

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>758 Silver Spring Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Gerald Wayne Thompson</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/11/21</u>
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucking firm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>installer</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. J. W. Thompson Silver Spring</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>516-20-5928</u>	
17. INFORMANT <u>Mrs. John P. O'Shea, 1653 N. Meade, Chicago</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fit on left ear & neck</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>gun</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell off boat and hit by propeller</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fallen off boat and hit on neck</u>	
20c. TIME OF INJURY Month, Day, Year <u>7/1/61</u>	20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20f. (City or town) (County) (State) <u>Bethesda Md. D. Calvert Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		DATE SIGNED <u>7/2/61</u>	
EXAMINER'S NAME (Type) <u>Harner E. Humphrey, Inc.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit-Burial</u>	22b. DATE THEREOF <u>7/10/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Acradia Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Chicago, Illinois</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harner E. Humphrey, Inc. 8434 Georgia Avenue Silver Spring, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 5 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **07749**

7758

1. PLACE OF DEATH o. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JULIA Middle L. Last THORNTON				4. DATE OF DEATH Month July Day 27 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 14, 1879	
9. AGE (In years last birthday) 81 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John C. Cunningham		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Lloyd L. Thornton, Chesapeake Beach, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordiany occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month _____ Day _____ Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 7-20, 1961 , to 7-27, 1961 , that I last saw the deceased alive on 7/27, 1961 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 7/27/61							
ACTUAL SIGNATURE [Signature] M.D. _____				PHYSICIAN'S NAME (Type) George J. Weems Huntingtown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 1, 1961		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Smethport, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home Owings Md.				24a. REC'D BY REGISTRAR DATE AUG 1 '61		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07750

1. PLACE OF DEATH a. COUNTY <i>Cabot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Georges</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deals</i>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Cabot Co. Hospital</i>		d. STREET ADDRESS <i>Mimosa Cove</i>	
3. NAME OF DECEASED (Type or print) <i>Edith Elizabeth Wheeler</i>		4. DATE OF DEATH Month <i>7</i> Day <i>17</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1895</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Wash D.C.</i>	
13. FATHER'S NAME <i>B. Chandler</i>		14. MOTHER'S MAIDEN NAME <i>W. Dymouth</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Thomas B. Wheeler Deals</i>		Address <i>Deals</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>904.0</i> DUE TO <i>kidney infection following</i> Conditions, if any, which gave rise to immediate cause (b) <i>fractured hip</i> DUE TO <i>80 days</i> (a), stating the underlying cause lost. (c) <i>fall at home</i>		INTERVAL BETWEEN ONSET AND DEATH <i>80 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>fell and fractured hip 80 days ago</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I and Part II of item 18.) <i>fell at home</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>May 19 61</i> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Deals</i> (County) <i>aa</i> (State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. WARD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>7/17/61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/20/61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Georgia Avenue Silver Spring, Maryland</i>	
24a. REC'D BY REGISTRAR <i>DATE JUL 19 61</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>	

